DOCUMENT RESUME

ED 281 136 CG 019 870

AUTHOR Kalichman, Seth C.; And Others
TITLE Incestuous Abuse: Licensed and Non-Licensed Clinicians' Attitudes and Reporting.
PUB DATE Aug 86
NOTE 9p.; Paper presented at the Annual Convention of the American Psychological Association (94th, Washington, DC, August 22-26, 1986). Best copy available.
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Adolescents; Age Differences; *Attribution Theory; Child Abuse; Children; *Child Responsibility; Client Characteristics (Human Services); *Compliance (Legal); Counselor Attitudes; Daughters; Fathers; *Incest; *Mental Health Clinics; Parent Child Relationship; *Parent Responsibility; Professional Personnel; Sexual Abuse

ABSTRACT

Victims of father-daughter incest may develop a number of social and emotional problems which motivate them to seek mental health services. A study was conducted to (1) investigate the patterns of father-daughter incest responsibility attribution by clinicians working within mental health facilities and (2) explore clinicians' tendency to report incest as a specific case of child abuse. Mental health professionals (N=71) at two mental health centers completed a four-part survey consisting of: (1) the Jackson Incest Blame Scale (JIBS); (2) a second measure of responsibility attribution; (3) two open-ended questions on awareness of state mandatory reporting laws and their tendency to report incest; and (4) a brief history of professional background. The results revealed that subjects attributed the greatest degree of responsibility to the father and the least to the daughter on all measures of responsibility attribution, and also attributed a substantial amount of responsibility to the mother. Compared to female clinicians, male clinicians were found to attribute significantly greater responsibility to the mother and to attribute significantly more responsibility to the daughter on the JIBS. Daughter age had a significant effect on the clinicians' attribution of responsibility to the father and daughter. Results also indicated significant differences between licensed and non-licensed clinicians in their knowledge of reporting laws and their tendency to report incest. Further research is needed to examine practitioners' differential treatment of abuse victims depending upon type of abuse involved and victim's age. (NB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED281136

BEST COPY AVAILABLE

Incestuous Abuse: Licensed and Non-licensed Clinicians' Attitudes and Reporting

Seth C. Kalichman
University of South Carolina
and
Northside Community Mental Health Center
Tampa, Florida

Mary E. Craig
Columbia University

Chris M. Crowe
University of South Carolina

Paper presented at the 94th Meetings of the American Psychological Association, August, 1986, Washington, D.C..

CG 019870

The authors wish to thank Northside Community Mental Health Center, Tampa, Florida, Hillsborough County Sexual Abuse Treatment Center and Broward County Mental Health Division for their participation in this project. We are indebted to Tony Broskowski for his continuous support and assistance, and to Linda Steinman for laying the foundation for this study.

Portions of this study were presented at the meeting of the Southeastern Psychological Association, March, 1986, Orlando, Florida.

For reprints, write to Seth C. Kalichman, Department of Psychology, University of South Carolina, Columbia South Carolina, 29208.

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Seth C. Kalichman

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Incestuous Abuse: Licensed and Non-licensed Clinicians' Attitudes and Reporting

Victims of father/daughter incest are known to develop a number of social and emotional problems including depression, sexual dysfunction, substance abuse and higher rates of suicide attempts (Browne and Finkelhor, 1986; Jackson and Ferguson, 1983; Finkelhor, 1984; Spencer, 1978). These difficulties are often presented years after the abuse has occured (Gelinas, 1983). A number of studies in the literature report a high incidence of incestuous abuse among girls admitted to psychiatric hospitals (Husain and Chapel, 1983; Spencer,1978; Rosenfeld, 1979). Although it seems reasonable to assume that the delivery of mental health services may be influenced by clinicians' attitudes (Alexander, 1980), no study in the literature has investigated mental health clinician's attitudes toward incest.

Another important issue in mental health professionals' treatment of incest victims is their tendency to report incestuous abuse. As a particular case of child abuse father/daughter incest is included under state mandatory reporting laws. Despite legal obligations, Swoboda, Elwork, Sales, and Levine (1978) found that 66% of licensed psychologists surveyed would not report a hypothetical case of child abuse. Other researchers have had similar results with teachers, family physicians and psychiatrists (Muehleman & Kimmons, 1981; Williams, Osborne & Rappaport, 1985). While there are several investigations of child abuse reporting, no study has specifically addressed the reporting of incestuous abuse.

The purpose of the present study was two-fold. First, we wanted to investigate the patterns of father/daughter incest responsibility attribution by clinicians working within mental health facilities. Clinician's sex, tendency to report incest, whether or not they are licensed, and the victim's age are investigated as variables contributing to levels of attributed responsibility. Second, clinicians' tendency to report incest as a specific case of child abuse was investigated.

Methods

Two mental health centers in Florida participated in this study. The centers are relatively similar in services provided, clients served and urbanity. Table 1 presents the distribution of subjects within different professional categories. Subjects participated voluntarily and were assured of anonymity and confidentiality.

Table 1
Licensed and Non-Licensed Groups of Mental Health Professionals n=71

	Licensed		Non-Licensed	
	Psychologists and Social Workers	Psychiatrists and Nurses	Adult Counselors	Adolescent Counselors
Male	10	3	10	10
Female	10	9	10	9

Paper-pencil surveys were distributed to subjects on their job sites and were completed individually. Each questionnaire consisted of four parts: 1) the Jackson Incest Blame Scale (JIBS), a factor-analytically derived twenty item likert scale measuring father/offender, daughter/victim, situation and society responsibility attribution. (Jackson and Ferguson, 1983); 2) a second measure of responsibility attribution involving subjects' assigning relative percentages of responsibility for father/daughter incest to the father, mother, daughter, situation and society (Alexander, 1980; Steinman, 1981). Responsibility was assigned to each source of attribution under three conditions of victim's age: when the victim was referred to as a child, an adolescent and of no specific age; 3) two open ended questions asking subjects to report their awareness of the state mandatory reporting laws and their tendency to report a case of incestuous abuse; and 4) a brief history of the subject's professional background.

RESULTS

Clinicians attributed the greatest degree of responsibility to the father and the least to the daughter on all measures of responsibility attribution. Clinicians were also found to attribute a substantial amount of responsibility to the mother in these families (16%). Tables 2 and 3 present mean JIBS and relative percentage scores for licensed and non-licensed clinicians, and subject sex.

Table 2
Mean Jackson Incest Blame Scale Scores for Professional Groups and Sexes

Professional Group and Subject Sex	JIBS Factor			
	Father	Daughter	Society	Situation
Licensed Clinicians	22.1	10.0	16.2	17.8
Non-Licensed Clinicians	22.0	9.9	16.1	17.9
Males	22.9	11.2*	15.1	18.1
Females	22.0	9.4	16.2	17.7

Table 3
Mean Assignments of Relative Percentages of Responsibility for Professional Group's and Sexes

Professional Group and Subject Sex	Relative Percentage Factor				
	Father	Mother	Daughter	Society	Situation
Licensed Clinicians	64%	16%	4%	3%	4%
Non-Licensed Clinicians	62%	16%	8%	5%	7%
Males	63%	22%*	5%	4%	5%
Females	64%	16%	8%	3%	7%

Analysis of variance indicated that male clinicians attributed significantly greater responsibility to the mother than female clinicians ($F=3.94, P<.05$). Analysis also revealed significant sex differences in subjects' scores on the Jackson Incest Blame Scale. On this measure, male

clinicians were found to attribute significantly more responsibility to the daughter in a father/daughter incest family ($F=7.4, p<.01$).

Manipulation of the daughter's age did not significantly effect levels of responsibility attributed to the mother, situation and society. However, the father was attributed significantly greater levels of responsibility when the daughter was referred to as a child or of no specific age than when referred to as an adolescent ($t=5.6, p<.001$). Also, adolescent victims were attributed significantly more responsibility for incest than child victims and victims of no specific age ($t=2.3, p<.05$). Table 6 presents mean percentages of attributed responsibilility as a function of the daughter/victim's age.

Table 4
Mean Assignments of Relative Percentages of Responsibility as a Function of Victim Age

Victim Age	Father	Mother	Daughter	Society	Situation
Child	68%*	19%	2%*	4%	5%
Adolesccent	63%	18%	8%*	4%	5%
Not Specified	63%	19%	6%*	3%	6%

Results also indicated significant differences between licensed and non-licensed clinicians in their knowledge of reporting laws and their tendency to report incest. Forty percent of non-licensed clinicians were unaware of the reporting laws and 25% responded that they would not report a case of incest. In contrast, all licensed clinicians responded that they knew the reporting laws and would report a case of incest.

Discussion

Mental health clinicians' patterns of attributing responsibility for incestuous abuse appear to be similar those of college students' reported by Steinman (1981) and Jackson and Ferguson (1983). This finding was unexpected in light of over 90% of our sample (n=64) having had contact with sexually abusive persons or victims, and the effect that contact with victims has on clinician's patterns of attribution (Alexander, 1980). There were no apparent differences between those having had contact and those who have not, although significance tests could not be performed

due to disproportionate cell sizes. However, a trend indicating differences in responsibility attributed to the victim between clinicians who work with children and those working with adults was noted. Clinicians working with children seemed to attribute less responsibility to the daughter/victim, although cell sizes again did not permit significance tests.

Males attributing greater levels of responsibility to the daughter/victim was found both in this study and also in a study of college students (Jackson and Ferguson, 1980). Therefore, the social values reflected in levels of responsibility attribution do not seem to change as a function of experience in working with abusers and victims.

Our results also found that clinicians attribute a substantial degree of responsibility to the mother in a father/daughter incest family. The mother in these families is a clinically important figure due to the number of cases referred to family therapy and the importance of family dynamics in the treatment of fathers and victims. Male clinicians' attributing a greater degree of responsibility to the mother may reflect a sex difference in perceiving a mother's role in the family. One possible explanation of this result, as indicated by subject's qualitative responces, is that males may be more inclined to believe that mothers should be highly attentive to all of the interactions in a family and therefore are assumed to know that the abuse is occuring.

Daughter/victim age had a significant effect on clinicians' attribution of responsibility to the father and daughter. Clinicians hold father/offenders more responsible for committing incest when their daughter is younger, and do not hold young child victims responsible. Adolescent victims being held substantially more accountable for incestuous abuse has direct clinical implications in the treatment of persons who have been victimized in adolescence and come for help later in life as well as adolescents who have been victimized since childhood (Gelinas, 1983; Courtois, 1979). Responsibility attributed to the mother did not change as a function of the victim's age, posssibly indicating that mothers in father/daughter incest families may be viewed as a more static influence, like society, rather than an active participant in the abuse.

Unlike those in previous studies of "child abuse reporting," all of the licensed clinicians in this study stated that they knew the reporting laws and would report a case of incestuous abuse. The discrepancy between these results suggests that clinicians view incestuous abuse differently than a generic case of child abuse and therefore treat it differently. Alternatively, this discrepancy may be due to sampling differences. This study investigated only clinicians employed by mental health facilities while other

studies sampled clinicians randomly through professional associations (Swoboda, et al., 1978; Muehleman, & Kimmons, 1981). It is possible that clinicians working within agencies face multiple consequences for failing to report child abuse and may therefore be more motivated to report. Another possible difference may lie in changes that have occurred in professionals' awareness of the law over the past decade.

The large number of non-licensed clinicians in this study not reporting incestuous abuse deserves consideration. Non-licensed clinicians commonly stated that they were more likely to console and comfort the child victim and find out how she would like the situation dealt with. The majority of subjects not reporting incest stated they were unaware of the reporting laws, Therefore, it seems essential to provide inservice training programs to educate all agency staff about the existence of reporting laws as well as the reality of the effects of reporting on the child, family and subsequent treatment.

Who a clinician holds responsible for incestuous abuse is likely to effect his/her delivery of professional services (Schneider, et al., 1979). Because experience may have less impact on attitudes towards incest than expected, it is suggested that clinicians' training include values clarification exercises to become aware of their attitudes about child abuse and the potential impact their attitudes have on clinical service delivery. The effectiveness of such training programs will require systematic and comprehensive evaluations.

Attitudes towards the spouse of an abusive parent also warrants further study. The nature of responsibility attributions to the mother in this study may reflect a number of different judgements. These attributions are of practical interest insofar as they reflect levels of perceived participation in the abuse.

Further research is called for in addressing the issue of professional's differential treatment of abuse victims depending upon the type of abuse involved as well as the victim's age. Controlled research should also investigate other factors which may influence professionals' attitudes and tendency to report such as the sex of the parent, the sex of the victim and the parent/child relationship.

REFERENCES

Alexander, C. S. (1980). The responsible victim: Nurses' perceptions of victims of rape. Journal of Health and Social Behavior, 21, 22-23.

Browne, A. & Finklehor, D. (1986). Impact of Child Sexual Abuse: A Review of the Research. Psychological Bulletin, 99, 66-77.

Courtois, C.A. (1979). The incest experience and its aftermath. Victimology: An International Journal, 4, 337-347.

Finkelhor, D.(1984). Child Sexual Abuse: New Theory and Research. New York:Free Press.

Gelinas, D.J. (1983). The persisting negative effects of incest. Psychiatry, 46, 312-332.

Husain, A., & Chapel, C. L. (1983). History of incest in girls admitted to a psychiatric hospital. American Journal of Psychiatry, 140, 591-593.

Jackson, T. L., & Ferguson, W. P. (1983). Attribution of blame in incest. American Journal of Community Psychology, 11, 313-322.

Muehleman, T., & Kimmons, C. (1981). Psychologists' views on child abuse reporting, confidentiality, life, and the law: An exploratory study. Professional Psychology, 12,631-637.

Rosenfeld, A. A., (1979). Incidence of a histiry of incest among 18 female psychiatric patients. American Journal of Psychiatry, 136, 791-795.

Schneider D.J., Hastorf, A.H. and Ellsworth, P.C. (1979). Person Perception. Massachusetts: Addison-Wesley.

Spencer, J. (1978). Father-daughter incest: A clinical view from the corrections field. Child Welfare, 9, 581-591.

Steinman, L. M. (1981). Attribution of responsibility to differing aged victims as a function of beliefs concerning the scope, and the effects of incestuous abuse. Unpublished manuscript, Pennsylvania State University.

Swoboda, J. S., Elwork, A., Sales, B. D., & Levine, D. (1978). Knowledge of and compliance with privileged communication and Child-Abuse-Reporting Laws. Professional Psychology, 9, 448-458.

Williams, M. S., Osborne, Y. M., & Rappaport, N. B. (1985 March). Child abuse reporting laws: Differences among professional groups in tendancy to report and knowledge of law. Paper presented at the meeting of the Southeastern Psychological Association, Atlanta.